Published in final edited form as:

Psychiatr Serv. 2009 October ; 60(10): 1302–1304. doi:10.1176/appi.ps.60.10.1302.

The Beck Initiative: A Partnership to Implement Cognitive Therapy in a Community Behavioral Health System

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Abstract

The Beck Initiative is a partnership between researchers and clinicians at a large university and an urban behavioral health managed care system. Both partners share a commitment to ensuring that consumers in the community have access to competently delivered, individualized, evidence-based mental health care and that the providers who serve them have the support they need to deliver high-quality evidence-based treatments. Central features of the program are individualized training and consultation in cognitive therapy for each provider agency and policies to promote the sustainability of the initiative and its continuing evolution to meet the needs of providers and consumers.

Despite substantial evidence that cognitive therapy is effective for a number of psychiatric disorders (1), consumer access to cognitive therapy and other evidence-based treatments remains limited, particularly in community settings. In response to this challenge, the Beck Initiative Training Program in Cognitive Therapy was developed as a collaboration between the University of Pennsylvania (UPenn); the Department of Behavioral Health and Mental Retardation Services (DBHMRS) of Philadelphia; the department's behavioral managed care organization, Community Behavioral Health (CBH); and DBHMRS-CBH providers. Through this initiative, we are working to make cognitive therapy available to consumers at every provider site in the network.

Overview of the Beck Initiative

The organization of the DBHMRS-CBH network and the availability of cognitive therapists at UPenn with expertise in a variety of areas are unique characteristics of the initiative. CBH is one of the largest behavioral health managed care organizations in the country devoted to serving low-income consumers and the only one operated by a governmental body. A nonprofit, 501c(3) corporation, CBH is under contract with the city to provide in-plan (that is, Medicaid-reimbursed) mental health and substance abuse treatment services to all Medicaid recipients in Philadelphia County. CBH in turn has contracted with approximately 200 treatment providers over a large urban area with a highly diverse population. Providers offer the full spectrum of services to adults, children, and adolescents. CBH providers are invited by DBHMRS to become part of the network of trained cognitive therapists.

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The authors report no competing interests.

With approval from the State Department of Public Welfare, the Beck Initiative has been funded since its implementation in May 2007 through reinvestment funds—surplus funds or “profits”—from the business operations of CBH. DBHMRS leads the operational side of the program, and UPenn leads the training activities. The Beck Initiative team at the university consists of trained cognitive therapists who have expertise treating depression, anxiety, substance use disorders, and schizophrenia and working with children and adolescents and forensic populations. Both partners share a commitment to ensuring that consumers have access to competently delivered, individualized, evidence-based care and that providers have the support they need to maintain their capacity to deliver high-quality treatments. Furthermore, our goal is to make the program self-sustaining within the network. We monitor outcomes through ongoing program evaluation, research, and quality assurance efforts. The hallmarks of the program have been intensive training and consultation, quality assurance, ongoing support, and innovative methods of implementing cognitive therapy in a variety of programs and settings. To our knowledge, it is one of the only large-scale efforts to implement cognitive therapy for a variety of presenting problems for adult consumers within a U.S. community mental health system.

The program follows the ACCESS training model (2). DBHMRS and UPenn work together with providers to develop training programs that will meet the needs of each provider agency. Generally, an initial workshop focuses on core cognitive therapy concepts and interventions for common problems, such as depression, anxiety, and substance use disorders, and their applicability to specific presenting problems and consumers with multiple diagnoses. Strategies for preventing suicide and relapse to high-risk behaviors are also emphasized. After the workshop, clinicians receive six months of consultation, which includes weekly feedback on digital audio-recorded therapy sessions.

Because cognitive therapy has demonstrated efficacy and effectiveness for a variety of diagnoses and problems, clinicians are trained to use a case formulation approach during the consultation phase to address common or challenging issues (3). Standards for successful completion of the program include regular attendance at most or all training activities, expert review of a minimum number of sessions, and achievement of a minimum competence score by the end of the six-month period. Recently, models of more cost-efficient group session review and consultation have been pilot-tested, including real-time coaching and modeling of the use of cognitive therapy in group therapy and milieu treatment settings. Training in cognitive therapy for schizophrenia has been introduced at sites that successfully completed the six-month consultation phase. In these settings, a number of groups receive such training, including peer support staff, multidisciplinary teams, and recovery specialists, to support consumers’ use of cognitive therapy strategies between sessions.

Considerations and strategies in program development

Essential elements of a program such as the Beck Initiative are a high level of support within a large behavioral health system, adequate funding, a team of instructors with expertise in the treatment model for a variety of presenting problems, a carefully developed training model, flexibility and collaboration, and support and enthusiasm from within the network of providers. We have relied heavily on the literature on dissemination and implementation (4,5) to guide the development of the program.

The Beck Initiative began through a series of meetings and discussions in 2006 between UPenn and DBHMRS-CBH over several months to establish a shared vision for the project. It was important to clarify expectations regarding the intensity of training that would be necessary to meet the initiative’s goals, issues of client confidentiality and the nature of the consultation, use of administrative records for program evaluation, potential sources of research funding,

and mutually acceptable programs of research. Once mutual goals and a shared mission were established, the initiative enjoyed a strong commitment at high levels of leadership at the DBHMRS and in the Psychiatry Department at UPenn. This commitment has in turn facilitated support and positive interactions throughout the network. From the start, UPenn and DBHMRS have both designated program directors to coordinate the program, communicate with the providers, and ensure that the program is running smoothly. As the program has developed, we have implemented policies and strategies to address challenges faced at each site.

A series of operational meetings is essential before training begins at a provider agency. At these meetings, in addition to operational details, we discuss the agency's training needs, the needs of the clientele at the agency, the clinician's views on the program, potential barriers, and requirements of the program. After initial details have been worked out, all stakeholders are provided with written copies of the plan and meet periodically throughout the training. Regular meeting attendance and demonstration of support by high-level DBHMRS and agency administrators have been essential to initial successes and sustainability within the agencies, and these expectations are set during preliminary discussions at each site.

Some challenges have arisen in ensuring that the intensity and duration of the training is not diminished because of time-sensitive competing demands on the clinical and support staff or practical constraints at the participating agencies. Given the financial pressure that agencies are under, it has been essential to reimburse them for time spent in program-related activities. However, even with financial support from and commitment of DBHMRS, some of the smaller agencies and newer programs have struggled to maintain adequate levels of staffing while team members were in training. Through communication at our preliminary meetings, we have been able to tailor the training schedule so training occurs when the agency has adequate coverage.

Support at several points within the system is also crucial. To increase the visibility of the project and to promote support throughout the system, we have conducted training sessions and workshops for staff at DBHMRS. We also provide regular updates to the DBHMRS administration. Within the agencies, it is crucial to build collaboration with clinicians before training. We ask the agency to consult with its clinical staff before agreeing to become a Beck Initiative site and to nominate clinicians who express interest and willingness to participate. Before training begins, we meet separately with clinicians to go over the details of the program and discuss their questions and concerns. We also emphasize that it is important that they be sure they are comfortable making a commitment to use cognitive therapy with some of their clients throughout the training phase, to participate regularly over several months, and to submit session recordings each week for feedback.

Finally, it has been important to collaborate with support staff to facilitate the timely transfer of recorded sessions to the training instructors by way of a secure server that complies with the privacy rule of the Health Insurance Portability and Accountability Act. The logistics of transferring recordings can be challenging if agencies do not have access to technology to collect the digital recordings and send them to UPenn efficiently, and it can be frustrating to clinicians when feedback is delayed as a result. Because of differences between agencies in resources, technology, and proximity to the university, staff at UPenn must be prepared to work closely with agency staff to resolve occasional technical and logistical challenges. Given the commitment required to complete training at multiple levels within agencies, we hold an annual luncheon to recognize the work that the providers have done and allow providers from across the network to meet and communicate.

Promoting sustainability

Recognizing that factors such as personnel turnover and the tendency to drift from the model can have an impact on long-term sustainability of the program, we have implemented a number

of strategies to promote ongoing, high-quality implementation. Requirements for agencies that wish to enter the program include a minimum of four clinicians who can participate in the program and allocation of time for biweekly cognitive therapy consultation provided by internal supervisors and trainers after the training phase is complete. Clinicians who successfully complete the training receive a certificate indicating that they have reached the specified skill level in implementing cognitive therapy; certificates must be renewed every two years. To renew, clinicians must attend at least 80% of the posttraining consultation meetings at their agency, engage in at least one continuing education activity in cognitive therapy, and submit a session recording for evaluation.

Within each agency, supervisors and trainers are identified and provided with additional training and support so that they can continue the consultation meetings after the training phase is complete. These early internal consultation meetings are recorded and reviewed by UPenn instructors, who provide feedback and support during the transition. Providers send reports of attendance, general discussion items, and requests for additional support for each internal consultation meeting to the Beck Initiative program director at DBHMRS. Supervisors and administrators at all Beck Initiative provider agencies meet quarterly to review progress and solve problems involving barriers that have been encountered.

In light of the turnover within agencies, it is important that new clinicians enter the agency's internal consultation to replenish or increase the number of trained clinicians at the agencies. Because supervisors within the agency generally have many responsibilities and time constraints that limit their ability to provide training and feedback to new trainees, we have adapted the program in several ways. Workshops are offered throughout the year, and agencies are invited to send their new clinicians. In addition, instructors and trainees regularly review sessions or segments and discuss feedback as a group throughout training to facilitate a smooth transition into peer supervision after training. This will allow new trainees to enter the group and receive support within the agency as they develop skills in cognitive therapy, while allowing previously trained clinicians to monitor treatment fidelity as a group.

At two newly established centers of excellence in cognitive therapy, which are housed within successful agencies, designated trainers are available to provide training and feedback to new personnel throughout the network, to provide additional instruction for internal consultation groups, and to run training workshops that are specifically tailored to the needs of individual programs. Finally, we have established a listserv for trained clinicians throughout the network to communicate, and we are developing Web-based training that will allow clinicians to learn or review basic interventions on their own schedules.

Current status and future directions

Since May 2007 more than 500 clinicians and DBHMRS personnel have attended a workshop through the Beck Initiative and nearly 100 clinicians and support staff at ten agencies have attended or are currently participating in training and intensive consultation. Some of the populations and settings that have been targeted include general outpatient settings, outpatient substance abuse programs, intensive programs for schizophrenia, forensic treatment teams, and adolescents at a school-based clinic. More than 90 care managers employed by CBH received training in case formulation and treatment planning to allow them to support the efforts of network clinicians. Trainees and consumers have indicated a high degree of satisfaction, and preliminary evaluation data appear promising.

Most clinicians complete the program with the ability to implement cognitive therapy with skill and fidelity to the model, and internal consultation groups meet regularly at agencies that have completed training. Well over 1,000 consumers have received treatment from trained

Beck Initiative clinicians. The initiative is currently funded by DBHMRS, but we are partnering to seek funding to conduct research on our training models and outcomes.

Conclusions

Our program has developed through the strong commitment of DBHMRS, UPenn, and provider agencies. Key to early successes have been the designation of personnel to oversee operations and regular face-to-face communication between providers, DBHMRS, and UPenn, even after training. In addition, our work to tailor cognitive therapy protocols for some of the most common presenting problems based on a case conceptualization model has allowed us to make the trainings relevant to varied providers. Although we anticipate challenges ahead as we work to implement cognitive therapy throughout the system, we are striving to ensure that the program is flexible and sustainable as well as consistent with its original vision.

Acknowledgments

Preparation of this column was supported by grants K99 MH080100 and P20 MH71905 from the National Institute of Mental Health. The authors acknowledge the efforts of the instructors, clinicians, and consumers whose valuable participation and feedback have shaped the program.

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